MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Outpatient Services • Local Educational Agency

February 2007 • Bulletin 388

Contents

Billing Tips for Medi-Cal Universal Claim Form Transition Period

Beginning April 23, 2007 through June 24, 2007, Medi-Cal will accept both versions of the professional claim form, either the *UB-92* or the *UB-04*. During this period, providers are encouraged to migrate their business processes away from the *UB-92*, depleting their form stock, in preparation for exclusive use of the *UB-04*.

Providers may choose to fully transition to the new *UB-04* claim form at any time during this two-month window before the use of the *UB-04* is mandatory. Beginning June 25, 2007, Medi-Cal will only accept the *UB-04*.

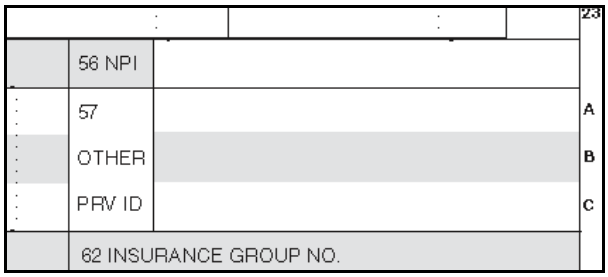
Separate billing instructions apply, as Medi-Cal is announcing a National Provider Identifier (NPI) dual-use period that starts during the claim form transition period. (For more information on the NPI implementation date, refer to the Medi-Cal Web site [www.medi-cal.ca.gov] and future *Medi-Cal Updates*.)

Providers billing on the new *UB-04* claim form must continue to use their Medi-Cal provider number until instructed otherwise. Beginning May 23, 2007, the NPI, if available, should be reported along with the Medi-Cal provider number, but is not necessary for proper adjudication.

For providers who choose to use the new claim form during the transition period, below are instructions on how to fill out the new form during the April 23 to June 24 time frame.

Providers may also continue to use the *UB-92* claim form during the transition period and bill as they do currently. To clarify, providers using the *UB-92* must use their Medi-Cal provider number. Only the new *UB-04* supports provision of both identifiers.

Boxes 56 and 57

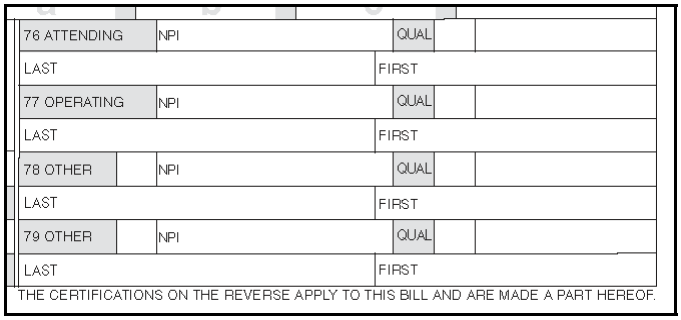


Providers can enter the billing provider's NPI in Box 56. In Boxes 57A – C, enter the billing provider's Medi-Cal number corresponding to information on lines 50 – 55A, B or C.

Please see **Billing Tips**, *page 2*

Billing Tips *(continued)*

Boxes 76 – 78



Outpatient Billers

In Box 76 (*Attending*), enter the referring or prescribing physician's Medi-Cal provider number in the farthest box to the right. This field is mandatory for radiologists. If the referring or prescribing physician is not a Medi-Cal provider, enter the state license in the farthest box to the right.

In Box 77 (*Operating*), enter the rendering physician's Medi-Cal provider number in the farthest box to the right. Only one rendering provider number may be entered per claim form. Do not use a group provider number or state license number.

Box 78 (*Other*) is not required by Medi-Cal for Outpatient billers.

For Boxes 76 and 77, providers can enter provider NPI numbers in the area marked "NPI."

Fresno Medi-Cal Field Office to Close

The Fresno Medi-Cal Field Office (FMCFO), located at 3374 East Shields Avenue, Suite C-4 in Fresno, California, will close no earlier than November 2007.

The closure is part of a statewide effort to streamline Medi-Cal field office operations and to increase consistency in *Treatment Authorization Request* (TAR) decisions on behalf of Medi-Cal recipients.

Note: The closure of other Medi-Cal field offices is not being considered, and the Medical Case Management (MCM) program will not be closing.

The majority of TAR services currently handled by the Fresno Field Office staff will be redirected to other Medi-Cal field offices. Hospital onsite review of TARs at area hospitals will continue, as will local MCM activities.

Provider notification regarding specific details on the redirection of the various TAR types adjudicated by the FMCFO to other Medi-Cal field offices will be provided in future *Medi-Cal Updates* as information becomes available. The California Department of Health Services (CDHS) does not anticipate any negative impact to providers or recipients as a result of the closure of the FMCFO, as all TAR and MCM services will continue.

Referral Update for LEA Audiology and Speech Therapy

Audiology and speech therapy treatment services require a written referral by a physician, dentist, licensed audiologist, or licensed speech-language pathologist within the practitioner's scope of practice, according to the *Code of Federal Regulations*, Section 440.110(c).

Licensed audiologists and licensed speech-language pathologists may not provide written referrals for audiological or speech-language assessments.

This information is reflected on manual replacement pages loc ed bil cd 1 thru 16 (Part 2), loc ed serv hear 3, 7 and 8 (Part 2), loc ed serv nurs 5 and 6 (Part 2), loc ed serv occu 4 (Part 2), loc ed serv phy 4 (Part 2), loc ed serv physician 5 thru 7 (Part 2), loc ed serv psych 6 thru 9 (Part 2), loc ed serv spe 2, 6 and 7 (Part 2), loc ed serv targ 5 (Part 2), loc ed serv trans 3 (Part 2) and loc ed serv vis 3 (Part 2).

LEA Services Billing Code Charts Update

As requested by the Office of HIPAA Compliance, the column headings that currently read "LEA Program Description" are revised to read "LEA Program Usage" in the Local Educational Agency (LEA) Services Billing Code Chart and the Procedure Codes/Service Limitations Charts in each service section.

California Children's Services Service Code Groupings Updates

Effective January 1, 2007, updates were made to California Children's Services (CCS) Service Code Groupings (SCGs) 01, 02, 03 and 07.

HCPCS codes X7582, X7588 and X7634 and CPT-4 code 90634 have been end-dated for dates of service on or after January 1, 2007.

In addition, HCPCS codes J9001, J9045 and J9310 and CPT-4 codes 20600, 20605, 20610, 20650, 20670, 20680, 20690, 20692 – 20694, 90384 – 90386, 90399, 90649, 90660, 90680, 90710, 90714 – 90715, 90734, 90740 and 90747 have been added for dates of service on or after January 1, 2007.

Reminder: SCG 02 includes all the codes in SCG 01 plus additional codes applicable only to SCG 02; SCG 03 includes all the codes in SCG 01 and SCG 02 plus additional codes applicable only to SCG 03; and SCG 07 includes all the codes in SCG 01 plus additional codes applicable only to SCG 07. These same "rules" apply to end-dated codes.

The updated information is reflected on manual replacement pages cal child ser 1, 3, 11 and 18 (Part 2).

Family PACT Clinic Dispensed Drugs and Contraceptive Drugs and Supplies Update

Pursuant to *Welfare and Institutions Code* (W&I Code), Section 14132.01, as amended by AB 77, of the Statutes of 2005, the Family PACT (Planning, Access, Care and Treatment) program is implementing fees for onsite dispensing of drugs and supplies.

Effective February 16, 2007, Clinic Dispensing Fees (CDF) for the Family PACT program are implemented for the following HCPCS Level III interim codes. These codes may be used by all Family PACT providers.

HCPCS Code	Description
X7706	(oral contraceptives)
X7716	(azithromycin 250mg tablets)
X7722	(emergency contraception)
X7728	(contraceptive patch)
X7730	(contraceptive vaginal ring)

For the codes listed above, the CDF is defined as the difference between the drug acquisition cost and the rate listed in the Medi-Cal Basic Rate table. The amount listed in the Medi-Cal Basic Rate table shall represent the Family PACT Fixed Claim Rate, which includes the CDF. This Fixed Claim Rate is multiplied by the number of units dispensed and the total is entered in the appropriate box on the claim form. This calculation method is not a change from current policy. However, the recognition of inclusion of the CDF as part of this Fixed Claim Rate is the published policy change.

Please see **Family PACT**, *page 4*

Family PACT *(continued)*

Providers who choose not to claim a dispensing fee shall continue to claim only the actual acquisition cost of the drug. Reimbursement shall be the lesser of the amount billed or the Medi-Cal limit.

There is no CDF for antibiotic or contraceptive injections, intrauterine contraceptives or contraceptive implants. Policies regarding claims submission for these items remain unchanged.

HCPCS Code X7706 (Oral Contraceptives) Updated Dispensing Limits
Refills are permitted after 14 days for each cycle dispensed (for example: 1 pack refill after 14 days; 3 packs refill after 42 days; and 13 packs refill after 182 days). The existing policy of a maximum quantity of 13 cycles dispensed per client, per provider remains. This policy change allows for the option of continuous use regimen.

Family PACT Formulary Additions
Effective for dates of service on or after February 16, 2007, the following drugs and contraceptive supplies are added to the Family PACT formulary for clinic and pharmacy dispensing:

- Ciprofloxacin XR 500 mg
- Miconazole 4 percent vaginal cream
- Clindamycin vaginal ovules 100 mg
- Nonoxynol-9 contraceptive sponge

HCPCS Codes Z7610 and X1500
Effective for dates of service on or after May 1, 2007, the following Family PACT policy updates apply to HCPCS codes Z7610 (miscellaneous drugs for non-surgical procedures) and X1500 (contraceptive supplies). The California Department of Health Services (CDHS), Maternal, Child and Adolescent Health/Office of Family Planning (MCAH/OFP) Branch, has developed a Family PACT Fixed Rate and quantity limit for each medication billed using code Z7610 and a Family PACT Fixed Rate and unit definition for each item billed with code X1500. This information follows in the Family PACT Price Guide.

Z7610
<u>This code may only be used by community clinics, hospital outpatient departments, emergency rooms and surgical clinics.</u>

Code Z7610 includes estradiol, most oral antibiotics, anti-virals and anti-fungals contained in the Family PACT formulary for clinic dispensing. Drugs billed with code Z7610 have no individual rates listed in the Medi-Cal Basic Rate table.

The overall rates in the Family PACT Price Guide are generally comparable to the net cost of the drug or supply to the Medi-Cal program. The methodology used to determine Family PACT Fixed Rates is available upon written request to the MCAH/OFP. Quantity limits for each drug are based on regimens previously defined in the Family PACT Program "2006 Provisional Clinical Services Benefits Grid," published in the June 2006 *Medi-Cal Update*.

CDFs for Z7610 apply once per drug, per claim. CDFs for medications billed with code Z7610 are defined as follows:

- Level A: pharmacist pre-packaged containers of tablets or capsules (flat rate); $3.00 per drug
- Level B: manufacturer pre-packaged tubes or other containers (flat rate); $2.00 per drug

For each Z7610 claim, providers must enter the following in the *Remarks* field (Box 84) on the *UB-92 Claim Form*:

- Name of the drug
- Dosage size
- Number of units dispensed multiplied by the FAMILY PACT Fixed Rate (the subtotal)
- CDF (if claimed)

Please see **Family PACT**, *page 5*

Family PACT *(continued)*

Providers must then calculate a total and enter it in the *Total Charges* field (Box 47) for the appropriate line.

The following table provides examples for completing a claim form for clinic dispensed drugs.

Remarks* field (Box 84) of the *UB-92 Claim Form				**Box 46**	**Box 47**
Drug Name	**Dosage size**	**Number of units dispensed multiplied by fixed claim rate (subtotal)**	**Plus CDF**	**Total Charges**	**"Service Units"**
Acyclovir	200 mg capsule	50 capsules X $0.15/capsule = $7.50	$ 3.00	$ 10.50	1
Butoconazole	2% SR cream/tube	1 tube X $29.33/tube = $29.33	2.00	31.33	1
Doxycycline Probenecid	100 mg tablets 500 mg tablets	28 tablets X $0.14 = $3.92 2 tablets X $0.71 = $1.42	3.00 3.00	11.34	1

Every Z7610 claim must have an acceptable secondary diagnosis code entered on the *UB-92 Claim Form* for reimbursement. Only one secondary diagnosis code can be processed per claim form.

When the same secondary diagnosis code applies to more than one Z7610 drug claimed, more than one regimen may be listed in the *Remarks* field (Box 84) of the claim form. If a combination of drug regimens is claimed under a single secondary diagnosis code, it should be entered as one (service) unit. If two or more drugs are dispensed with different secondary diagnoses, then a separate claim form must be submitted for each secondary diagnosis and its corresponding drug(s). If the *Remarks* area is left blank, the claim will be denied.

X1500

Contraceptive supplies that may be billed by all Family PACT providers with code X1500 include the following: male or female condoms, spermicides, lubricants, diaphragms, cervical caps and basal temperature thermometers. These supplies are dispensed alone or in combination and are currently subject only to a maximum Medi-Cal basic rate, which is currently $14.99.

The overall rates are generally comparable to the net cost of the drug or supply to the Medi-Cal program. The methodology used to determine Family PACT Fixed Rates is available upon written request from the OFP.

The CDF for contraceptive supplies claimed under code X1500 is defined as follows:

- Level C: Contraceptive Supplies, ten percent of contraceptive supply claim (rounded to the nearest cent)

The combined total of all supplies plus CDF cannot exceed the Medi-Cal basic rate for code X1500.

To avoid denials on claims, providers billing for code X1500 must enter the following in the *Reserved for Local Use* field (Box 19)/*Remarks* field (Box 84) of the claim form: the quantity of condoms, film, suppositories, contraceptive sponges, diaphragms, cervical caps or grams of spermicide/lubricant dispensed.

Multiply the number of each product by the fixed claim rate for each product and add a dispensing fee equal to ten percent of the sum for individual products to calculate the total amount claimed for code X1500. The total is entered in the *Charges* field (Box 24F)/*Total Charges* field (Box 47) of the claim form and shall not exceed the Medi-Cal limit.

The following table provides examples for completing a claim form for clinic dispensed drugs.

Remarks* field (Box 84) of the *UB-92 Claim Form ***Reserved for Local Use* field (Box 19) of the *HCFA 1500* claim form**				**Box 47/ Box 24F**	**Box 46/ Box 24G**
Supply Name	**Unit**	**Number of units dispensed multiplied by fixed claim rate (subtotal)**	**Plus 10% CDF**	**Claim total**	**"Units" on claim**
Male condoms	1 condom	35 condoms X $0.28/condom = $9.80	$ 0.98	$ 10.78	1
Spermicidal foam	1.4 oz. can	1 can (40 grams) X $0.21/gram = $8.40	0.84	9.24	1

Please see **Family PACT**, *page 6*

Family PACT *(continued)*

The following tables, "Family PACT Price Guide," are the dispensing guidelines for covered drugs, dosage size/billing unit, maximum billing units per claim, the Family PACT rate per unit, the maximum drug cost, the clinic dispensing fee, the upper payment limit and the fill frequency (days). The Family PACT Price Guide will be updated periodically and will be posted on the Family PACT Web site at **www.familypact.org**.

Medication	Dosage Size/ Billing Unit	Maximum Billing Units per Claim	Family PACT Rate per Unit	Maximum Drug Cost	Clinic Dispensing Fee	Upper Payment Limit	Fill Frequency (days)
Acyclovir	200 mg caps	50	$ 0.15	$ 7.50	$ 3.00	$ 10.50	30
Acyclovir	400 mg tabs	30	0.23	6.90	3.00	9.90	30
Acyclovir	400 mg tabs	60	0.23	13.80	3.00	16.80	30
Acyclovir	800 mg tabs	10	0.47	4.70	3.00	7.70	30
Azithromycin	1 g packet	1	17.18	17.18	2.00	19.18	7
Azithromycin	1 g packet	2	17.18	34.36	2.00	36.36	7
Azithromycin	500 mg tabs	4	10.64	42.56	3.00	45.56	7
Butoconazole	2% tube	1	29.33	29.33	2.00	31.33	30
Cefpodoxime	200 mg tabs	2	3.83	7.66	3.00	10.66	7
Cephalexin	250 mg caps	40	0.18	7.20	3.00	10.20	7
Cephalexin	500 mg caps	20	0.36	7.20	3.00	10.20	7
Ciprofloxacin	250 mg tabs	2	0.38	0.76	3.00	3.76	7
Ciprofloxacin	250 mg tabs	6	0.38	2.28	3.00	5.28	7
Ciprofloxacin	500 mg tabs	6	0.45	2.70	3.00	5.70	7
Ciprofloxacin	500 mg tabs	1	0.45	0.45	3.00	3.45	7
Ciprofloxacin XR	500 mg tabs	3	5.82	17.46	3.00	20.46	7
Clindamycin	150 mg caps	28	0.92	25.76	3.00	28.76	30
Clindamycin	100 mg ovules/3pk	1	29.70	29.70	2.00	31.70	30
Clindamycin	2% tube	1	35.86	35.86	2.00	37.86	30
Clindamycin SR	2% tube	1	52.50	52.50	2.00	54.50	30
Clotrimazole	1% tube	1	6.82	6.82	2.00	8.82	30
Clotrimazole	2% tube	1	7.16	7.16	2.00	9.16	30
Clotrimazole	100 mg pack	1	6.21	6.21	2.00	8.21	30
Clotrimazole	200 mg pack	1	7.57	7.57	2.00	9.57	30
Doxycycline	100 mg caps/tabs	28	0.14	3.92	3.00	6.92	30
Doxycycline	100 mg caps/tabs	56	0.14	7.84	3.00	10.84	30
Doxycycline	100 mg caps/tabs	14	0.14	1.96	3.00	4.96	7

Please see **Family PACT**, *page 7*

Family PACT *(continued)*

Medication	Dosage Size/ Billing Unit	Maximum Billing Units per Claim	Family PACT Rate per Unit	Maximum Drug Cost	Clinic Dispensing Fee	Upper Payment Limit	Fill Frequency (days)
Estradiol	0.5 mg tabs	30	0.18	5.40	3.00	8.40	30
Estradiol	1 mg tabs	30	0.22	6.60	3.00	9.60	30
Estradiol	2 mg tabs	30	0.31	9.30	3.00	12.30	30
Fluconazole	150 mg tab	1	9.65	9.65	2.00	11.65	30
Imiquimod	5% pack	1	124.73	124.73	2.00	126.73	30
Metronidazole Gel	0.75% tube	1	$ 35.04	$ 35.04	$ 2.00	$ 37.04	30
Metronidazole	250 mg tabs	56	0.08	4.48	3.00	7.48	30
Metronidazole	250 mg tabs	28	0.08	2.24	3.00	5.24	7
Metronidazole	500 mg tabs	4	0.22	0.88	3.00	3.88	7
Metronidazole	500 mg tabs	28	0.22	6.16	3.00	9.16	30
Metronidazole	500 mg tabs	14	0.22	3.08	3.00	6.08	7
Miconazole	100 mg pack	1	6.75	6.75	2.00	8.75	30
Miconazole	200 mg pack	1	13.77	13.77	2.00	15.77	30
Miconazole	2% tube	1	7.17	7.17	2.00	9.17	30
Miconazole	4% tube	1	7.30	7.30	2.00	9.30	30
Miconazole	200 mg 2% pack	1	8.94	8.94	2.00	10.94	30
Nitrofurantoin SR	100 mg caps	20	1.51	30.20	3.00	33.20	30
Nitrofurantoin	100 mg caps	40	1.28	51.20	3.00	54.20	30
Ofloxacin* (PID only)	200 mg tabs	56	2.17	121.52	3.00	124.52	30
Ofloxacin* (PID only)	400 mg tabs	28	4.35	121.80	3.00	124.80	30
Podofilox	0.50% pack	1	76.88	76.88	2.00	78.88	30
Probenecid	500 mg tabs	2	0.71	1.42	3.00	4.42	30
SMX/TMP	400-80 mg tabs	28	0.12	3.36	3.00	6.36	7
SMX/TMP	800-160 mg tabs	14	0.15	2.10	3.00	5.10	7
Terconazole	0.40% tube	1	43.43	43.43	2.00	45.43	30
Terconazole	0.80% tube	1	39.74	39.74	2.00	41.74	30
Terconazole	80 mg pack	1	34.05	34.05	3.00	37.05	30
Tinidazole	250 mg tabs	8	1.38	11.04	3.00	14.04	7
Tinidazole	500 mg tabs	4	2.76	11.04	3.00	14.04	7

* Ofloxacin tablets are only payable when secondary ICD-9-CM diagnosis codes 614.0, 614.2 or 615.0 are included in the other diagnosis *Code* field (Box 68) of the *UB-92 Claim Form*.

Please see **Family PACT**, *page 8*

Family PACT *(continued)*

Contraceptive Supplies	Unit	Reimbursement Per Unit
Male Condoms	each	$ 0.28
Female Condoms	each	2.76
Spermicidal Suppositories	each	0.53
Spermicidal Film	each	0.69
Spermicidal Gel/Jelly/Cream/Foam	gram	0.21
Lubricant (non-spermicidal)	gram	0.03
Nonoxynol 9 Contraceptive Sponge	each	2.35
Basal Body Thermometer	each	5.53

Providers who choose not to claim a dispensing fee should continue to claim only the actual acquisition cost of the drug. Reimbursement is the lesser of the amount billed or the Medi-Cal upper payment limit.

Revised *Family PACT Policies, Procedures and Billing Instructions* (PPBI) manual pages will be issued in a future mailing to Family PACT providers. For more information about Family PACT, call the Telephone Service Center (TSC) at 1-800-541-5555 from 8 a.m. to 5 p.m. Monday through Friday, except holidays, or visit the Family PACT Web site at **www.familypact.org**.

Instructions for Manual Replacement Pages — Part 2

February 2007

Local Educational Agency Bulletin 388

Remove and replace:

cal child ser 1 thru 24
loc ed bil cd 1 thru 16
loc ed serv hear 3/4, 7/8
loc ed serv nurs 5/6
loc ed serv occu 3/4
loc ed serv phy 3/4
loc ed serv physician 5 thru 7
loc ed serv psych 5 thru 9
loc ed serv spe 1/2, 5 thru 7
loc ed serv targ 5
loc ed serv trans 3
loc ed serv vis 3